



Maternal and Child Health Bureau

**Seminars on Adolescent Health:
Prevention of Adolescent Suicide
June 25, 2003**

Health Resources and Services Administration
Maternal and Child Health Bureau

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**Youth Suicide Prevention:
Mental Health and Public Health
Perspectives**

(A Presentation and a Training Aid)

Prepared by the staff of the Center for Mental Health in Schools
at UCLA

The Center is co-directed by Howard Adelman and Linda Taylor and operates under the auspices of the School Mental Health Project, Dept. of Psychology, UCLA. Write: Center for Mental Health in Schools, Box 951563, Los Angeles, CA 90095-1563. Phone: (310) 825-3634 Fax: (310) 206-8716
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Presentation Overview

- I. Youth suicide in the U.S. –
How big is the problem?
- II. What do prevention programs try to do?
- III. Framework for a public health approach
- IV. Guiding decision makers to model programs
- V. The key role schools can play
- VI. A few cautions
- VII. Finding other training aids

I. Youth suicide in the U.S. – How big is the problem?



Suicide in the United States - The Problem

- More people die from suicide than from homicide.
- Overall, suicide is the eighth leading cause of death for all Americans, and is the third leading cause of death for young people aged 15-24.
- Males are four times more likely to die from suicide than are females. However, females are more likely to attempt suicide than are males.
- White males and white females accounted for over 90% of all suicides.
- Suicide rates are generally higher than the national average in the western states and lower in the eastern and midwestern states.
- Nearly 3 of every 5 suicides (58%) were committed with a firearm.

Sources: *National Center for Injury Prevention & Control*
<http://www.cdc.gov/ncipc/factsheets/suifacts.htm>

National Center for Health Statistics - Wonder Database
<http://www.cdc.gov/mort/CD9J.shtml>

Suicide Among the Young

- Persons under age 25 accounted for 15% of all suicides; older adolescents are more likely than younger ones to commit suicide.
- For young people 15-24 years old, suicide is the third leading cause of death, behind unintentional injury and homicide.
- Among persons aged 15-19 years, firearm-related suicides accounted for 62% of the overall increasing suicide rate from 1980 through the 1990s.
- The risk for suicide is greatest among young white males; however, from 1980 through the 1990s, suicide rates increased most rapidly among young black males; American Indian and Alaskan Native adolescents have the highest rates.
- Although suicide among the young is relatively rare and rates have plateaued for adolescents as a whole, the problem remains a dramatic one and intensified efforts are needed to prevent suicide among young people.

Sources: *National Center for Injury Prevention & Control*
<http://www.cdc.gov/ncipc/factsheets/suifacts.htm>

National Center for Health Statistics - Wonder Database
<http://www.cdc.gov/mort/CD9J.shtml>

Suicide: Cost to the Nation

- One group of researchers states: "In economic and human terms, youth suicide in the United States is a public health problem of the first magnitude." Based on data available in 1980, they estimate that the cost to society was \$2.27 billion.¹
- In contrast, others suggest that such figures are overestimates because youth suicide often results in net economic savings by cutting short the need for treatment and other social benefits for those who are seriously disturbed and marginal society members.²
- Beyond the economic debate, most agree that concern for suicide prevention is an indicator of a humane society. And, any society that fails to attend to youth suicide prevention has too limited a commitment to the well-being of young people and will pay a price for this lack of concern.

¹Weinstein, M.C., & Saturno, P.J. (1989). Economic impact of youth suicides and suicide attempts. In *Report of the secretary's task force on youth suicide*. (Vol. 4, pp. 82-93). Washington, DC: GPO.
²Lester, D., & Yang, B. (2001). *The economic cost of suicide*. As reported in D. Lester (2003). Adolescent suicide from an international perspective. *American Behavioral Scientist*, 46, 1157-1170.

Why would a young person attempt suicide?

- Too many are unhappy – for different reasons
 - > environmental/community/system deficits (e.g., impoverished neighborhoods & schools)
 - > family factors (e.g., economic reversals, conflict)
 - > peer factors (e.g., rejection, alienation)
 - > psycho-biological factors (e.g., predisposition)
- Need to be careful not to overpathologize*

*See *The Classification of Child and Adolescent Mental Diagnoses in Primary Care (DSM-PC)* – developed by the American Academy of Pediatrics for a useful resource to help counter tendencies to overpathologize.

II. What do prevention programs try to do?

- Enhance awareness and increase information among students, staff, family, and community
- Change environments and systems – with particular concern for diversity
- Enhance identification of those at risk and build capacity of school, family, & community to help
- Enhance competence/assets related to social and emotional problem solving (e.g., stress management, coping skills, compensatory strategies)
- Enhance Protective Buffers

III. Framework for a public health approach



Interconnected Systems for Meeting the Needs of All Youth

School Resources
(facilities/stakeholders/
programs/services)

- Examples:
- General health education
 - Drug and alcohol education
 - Enrichment programs
 - Support for transitions
 - Conflict resolution
 - Home involvement

- Drug counseling
- Pregnancy prevention
- Violence prevention
- Dropout prevention
- Suicide prevention
- Learning behavior accommodations
- Work programs

- Special education for learning disabilities, emotional disturbance, and other health impairments

Systems for Promoting Healthy Development & Preventing Problems

primary prevention – includes universal interventions
(low end need/low cost per individual programs)

Systems of Early Intervention
early-after-onset – includes selective & indicated interventions
(moderate need, moderate cost per individual)

Systems of Care
treatment/indicated interventions for severe & chronic problems
(High end need/high cost per individual programs)

Community Resources
(facilities/stakeholders/
programs/services)

- Examples:
- Public health & safety programs
 - Prenatal care
 - Immunizations
 - Recreation & enrichment
 - Child abuse education

- Early identification to treat health problems
- Monitoring health problems
- Short-term counseling
- Foster placement/group homes
- Family support
- Shelter, food, clothing
- Job programs

- Emergency/crisis treatment
- Family preservation
- Long-term therapy
- Probation/incarceration
- Disabilities programs
- Hospitalization
- Drug treatment

Systemic collaboration is essential to establish interprogram connections on a daily basis and over time to ensure seamless intervention within each system and among systems of prevention, systems of early intervention, and systems of care.

(Developed by H. S. Adelman and L. Taylor and circulated through the Center for Mental Health in Schools at UCLA)

The figure illustrates a continuum spanning primary, secondary, and tertiary prevention – including universal, selective, and indicated interventions.

The interventions must be woven into three overlapping systems:

- a system for positive development and prevention of problems (which includes a focus on wellness or competence enhancement)
- a system of early intervention to address problems as soon after their onset as feasible
- a system of care for those with chronic and severe problems.

The continuum incorporates a holistic and developmental emphasis that encompasses individuals, families, and the contexts in which they live, work, and play.

It also provides a framework for adhering to the principle that we should use the least restrictive and nonintrusive forms of intervention needed to appropriately respond to problems and accommodate diversity.

Most importantly, full development of the overlapping systems is essential to stemming the tide of referrals for specialized assistance.

Currently, the only one of these systems that is even marginally in place is the system of care.

This has resulted in what has been described as a ***waiting for failure*** approach.

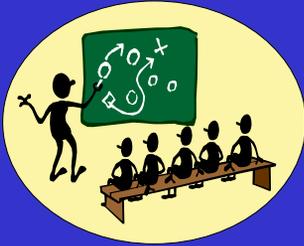
Until the other systems are well-developed, we will continue to inappropriately flood deep-end services and make it virtually impossible for them to do their work effectively.

Braiding Resources and Building Capacity

Development of a full continuum involves community and school collaboration.

- Policy
(e.g., supporting development of the full continuum)
- Infrastructure
(e.g., collaborative mechanisms)
- Training
(e.g., leaders, primary care providers)

IV. Guiding decision makers to model programs



» *National Strategy for Suicide Prevention* (2001).
<http://www.mentalhealth.org/suicideprevention>

» *Reducing Suicide: A National Imperative* (2002).
Institute of Medicine (National Academy Press). See
Chapter 8 for reviews of "Programs for Suicide
Prevention."
<http://www.nap.edu/books/0309083214/html/273.html>

» *Youth Suicide Prevention Programs:
A Resource Guide* (1992) – CDC
<http://www.cdc.gov/ncipc/dvp/Chapter%201.PDF>

» *School Interventions to Prevent Youth Suicide. A Technical Aid
Sampler* (Center for Mental Health in Schools at UCLA)
<http://smhp.psych.ucla.edu>

» Kalafat, J. (2003) School approaches to youth suicide
prevention. *American Behavioral Scientist*, 46, 1211-
1223.

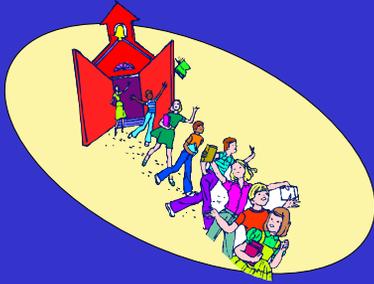
Promoting Healthy Social-Emotional Development

» *Safe and Sound. An Educational Leader's Guide to
Evidence-Based Social & Emotional Learning Programs*
(2002). The Collaborative for Academic, Social, and
Emotional Learning (CASEL).
<http://www.casel.org>

» *Positive Youth Development in the United States:
Research Findings on Evaluations of Positive Youth
Development Programs* (2002). Social Develop. Res.
Group, Univ. of Wash.

See Online journal *Prevention & Treatment*
<http://journals.apa.org/prevention/volume5/pre0050015a.html>

V. The key role schools can play



Why should schools play a role?

- Schools cannot achieve their mission of educating the young when students' problems are major barriers to learning and development. As the Carnegie Task Force on Education has stated: **School systems are not responsible for meeting every need of their students. But when the need directly affects learning, the school must meet the challenge.**
- Schools are at times a source of the problem and need to take steps to minimize factors that lead to student alienation and despair. _____
- Schools also are in a unique position to promote healthy development and protective buffers, offer risk prevention programs, and help to identify and guide students in need of special assistance.

Suicidal Assessment - checklist (Suggested points to cover with student/parent)

- (1) PAST ATTEMPTS, CURRENT PLANS, AND VIEW OF DEATH**
 - ✓ Does the individual have frequent suicidal thoughts?
 - ✓ Have there been suicide attempts by the student or significant others in his or her life?
 - ✓ Does the student have a detailed, feasible plan?
 - ✓ Has s/he made special arrangements as giving away prized possessions?
 - ✓ Does the student fantasize about suicide as a way to make others feel guilty or as a way to get to a happier afterlife?
- (2) REACTIONS TO PRECIPITATING EVENTS**
 - ✓ Is the student experiencing severe psychological distress?
 - ✓ Have there been major changes in recent behavior along with negative feelings and thoughts?
- (3) PSYCHOSOCIAL SUPPORT**
 - ✓ Is there a lack of a significant other to help the student survive?
 - ✓ Does the student feel alienated?
- (4) HISTORY OF RISK-TAKING BEHAVIOR**
 - ✓ Does the student take life-threatening risks or display poor impulse control?

Follow-through steps after assessing suicidal risk

- Avoid saying anything demeaning or devaluing, while conveying empathy, warmth, and respect.
- Explain the importance of and your responsibility for breaking confidentiality in the case of suicidal risk.
- Be certain the student is in a supportive and understanding environment.
- Try to contact parents by phone.
- If a student is considered to be in danger, only release her/him to the parent or someone who is equipped to provide help.
- Follow-up with student and parents to determine what steps have been taken to minimize risk.
- Document all steps taken and outcomes. Plan for aftermath intervention and support.
- Report child endangerment if necessary.

VI. A few cautions



- Even well trained professionals using the best available assessment procedures find it challenging to determine whether an individual is suicidal.
- **Large-scale screening** usually generates too many false positives and thus leads to over-referral and inappropriate consumption of scarce resources
- Involvement of students in looking for and reporting problems can run counter to efforts designed to promote empathy, caring, social support, and a sense of community.

VII. Finding other training aid



Go to:

- *National Mental Health Information Center*
<http://www.mentalhealth.org/cmhs/default.asp>
- *Centers for Disease Control and Prevention*
<http://cdc.gov/ncipc/factsheets/suifacts.htm>
- *Bright Futures in Practice: Mental Health*
www.brightfutures.org

And, of course, the two national centers
focused on mental health in schools:

- *Center for Mental Health in Schools* at UCLA
<http://smhp.psych.ucla.edu>
- *Center for School Mental Health Assistance*
at the University of Maryland, Baltimore
<http://csmha.umaryland.edu/>

Some Specific Aids to Download from our Website

<http://smhp.psych.ucla.edu>

- » *Suicide Prevention*
(a "Quick Training Aid")
- » *School Interventions to Prevent Youth Suicide.*
(a "Technical Aid Sampler")
- » *Youth Suicide/Depression/Violence*
(article in the Center's quarterly newsletter)
- » *Suicide Prevention*
("Quick Find" topic containing all the above
along with references and links to other
relevant resources)

**Planning to Prevent Youth
Suicide**

Lloyd Potter
Children's Safety Network

Topics

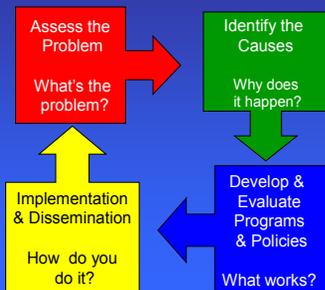
- Suicide Prevention Background
- Planning for prevention – States and Schools

Title V Block Grant Performance Measures

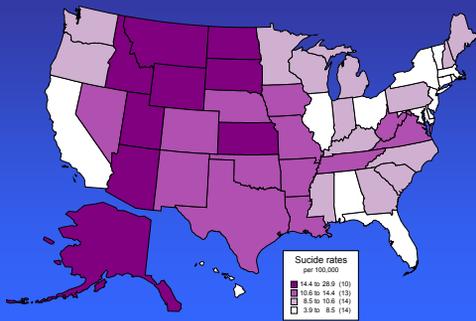
Core National Objectives

Performance Measure 16: The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

The Public Health Approach to Prevention

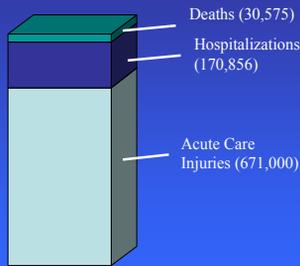


Suicide rates among youth aged 15-19 years by state, 1996-1998



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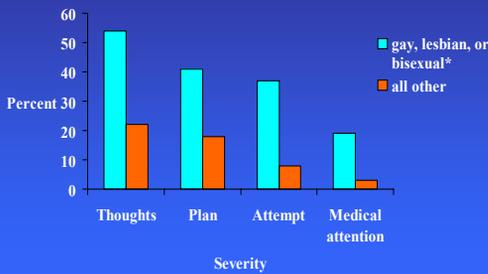
Mortality and morbidity from suicidal behavior, 1998



Sources: Death certificates
Natl. Hospital Discharge Survey
Natl. Hospital Ambulatory Medical Care Survey

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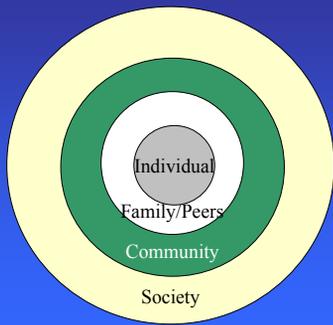
Severity of suicidal ideation and behavior of high school youth, by sexual orientation, Massachusetts, 1997



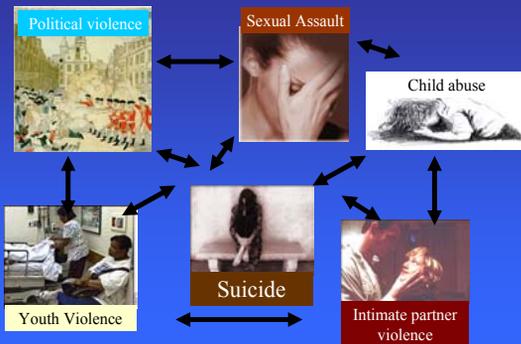
* and/or those who had any same-sex sexual experience
Source: Massachusetts Youth Risk Behavior Survey Results, 1998

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Spheres of Influence:
Ecological perspective of development



Forms of violence are inter-related

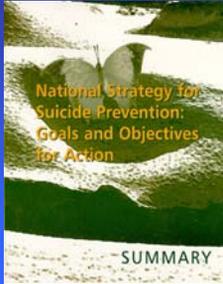


Suicidal behavior and risk factors are present among many perpetrators of youth violence



National Strategy for Suicide Prevention

www.mentalhealth.org/suicideprevention/



Provides guidance and suggests activities on suicide prevention

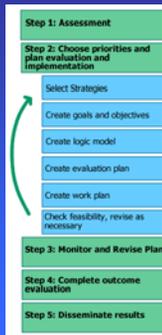
KEY COMPONENTS: State Suicide Prevention Program

- SUICIDE PREVENTION COORDINATOR
- FUNDING
- ADVOCACY
- NEEDS ASSESSMENT
- DATA IMPROVEMENT
- INTERVENTION PLAN
- SUPPORT AND GUIDANCE FOR LOCAL PROGRAMS
- EVALUATION
- COLLABORATION

PARTNERS

- HEALTH/PUBLIC HEALTH
- MENTAL HEALTH
- LAW ENFORCEMENT
- MEDICAL EXAMINER
- FAMILY SURVIVORS
- EDUCATION
- SUBSTANCE ABUSE
- JUVENILE JUSTICE
- FAITH-BASED ORGANIZATIONS

A model for state suicide prevention planning and evaluation



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State plans (n=24)

- CDC list*
- Reviewed hard copies and www.stateplans.org
- States:
AL, AZ, CO, GA, KA, LA, ME, MN, MD, MO, MT, MS, NE, NH, ND, OH, OK, OR, PA, RI, TN, VA, WA, WI

* Minus IA, NM, VT, WY, FL plus GA

Source: Debra Stone – National Center for Suicide Prevention Training

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Most common objectives*

- 1.1 Public education
- 6.5 Gatekeeper training (schools)
- 7.2 Assessment in primary care
- 8.3 Mental health and SA screening/referral
- 9 Media education
- 11.4 Improved surveillance

Other Crisis response teams, hotlines

* Found in at least 75% of plans; taken from NSSP

24 Plans Reviewed by Debra Stone

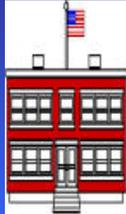
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State Plan Observations

- Comprehensive planning
- States erred on the side of being over-ambitious
- Collaboration evident
- Few evaluation or implementation plans
- Objectives difficult to measure
- Frequent mention of crisis response (i.e. hotlines)

Comprehensive school planning

- Preventing suicide – programs, services
- Handling suicidal crises
- Responding appropriately and effectively after a suicide occurs



Programs for the Prevention of Suicide Among Adolescents and Young Adults

- School gatekeeper training
- Community gatekeeper training
- General suicide education
- Screening programs
- Peer support programs



Programs for the Prevention of Suicide Among Adolescents and Young Adults (continued)

- Crisis Centers and hotlines
- Restriction of access to lethal means
- Intervention after a suicide



Promising Strategies



- Home visitation
- Parent training
- Mentoring
- Social cognitive



Common Youth Suicide Prevention Strategies Utilized in Prevention of Other Forms of Violence

	Youth Violence	Sexual Assault	Intimate Partner	Child Abuse
Gatekeeper Training	✓		✓	✓
Education	✓	✓		
Screening		✓	✓	✓
Peer support	✓	✓	✓	
Crisis centers		✓	✓	
Restrict lethal means	✓		✓	
Post-event intervention	✓	✓	✓	✓

TIP of the ICEBERG

- Suicide prevention can be incorporated into many places
- Much suicide prevention is disguised as other programs and efforts
- Suicide prevention involves everyone
- Planning and partnerships are key



Resources for States



www.ChildrensSafetyNetwork.org



www.SPRC.org



www.NCSPT.org

Adolescent Health Webcast

Columbia TeenScreen® Program

Leslie C. McGuire, M.S.W.

June 25, 2003

**The Carmel Hill Center
at
Columbia University**

THE PROBLEM OF MENTAL ILLNESS AND SUICIDE IN YOUTH

- 750,000 teens are depressed at any one time
 - 60–80 percent go untreated
- 7-12 million youth suffer from mental illness
 - 2 out of 3 do not receive treatment
- Suicide = 3rd cause of death in 15-19 year-olds
 - 19% contemplate suicide
 - 9% make an attempt
 - 3% make an attempt requiring med. attn.
- Effective screening tools are available
- Effective treatments are available

PSYCHIATRIC DISORDER IN ADOLESCENT SUICIDE

- 90% of teens who commit suicide suffer from mental illness
- 63% are symptomatic for more than a year before their suicides
- The most common risk factors are:
 1. Mood disorder
 2. Drug/alcohol abuse
 3. Past suicide attempt

POSITIVE ACTION FOR TEEN HEALTH (PATH)

- National Advisory Council launch on 1/28/03 and media launch on 2/20/03
- Mental health check ups for all youth before high school graduation
- Promote a public health priority
- Move research into practice
- Forge partnerships with advocates, state departments of mental health, education associations and service agencies

National Organizations That Have Endorsed Universal Mental Health Screening for Youth

- American Academy of Child and Adolescent Psychiatry
- American Mental Health Counselors Association
- American Psychiatric Association
- Anxiety Disorders Association of America
- Child and Adolescent Bipolar Foundation
- Depression and Bipolar Support Alliance
- Federation of Families for Children’s Mental Health
- Girls and Boys Town of America
- International Society of Psychiatric Mental Health Nurses
- National Association of County Behavioral Health Directors
- National Association of School Psychologists
- School Social Work Association of America
- Tourette Syndrome Association
- United States Conference of Catholic Bishops

COLUMBIA TEENSCREEN® PROGRAM

– HISTORY –

1991: Pilot Study

- Funded by NIMH and CDC
- 7 screening sites in metro NY
- 1,700 subjects

1995: Public Service Screening Projects Begin

- 24 screening projects in metro NY

1998: Follow-Up Study

- 533 subjects

1999: National TeenScreen® Program Launch

**2003: 70 sites trained in 27 states
PATH Launch**

COLUMBIA UNIVERSITY SCREENING SITES IN THE U.S.



COLUMBIA TEENSCREEN® PROGRAM

- POTENTIAL SCREENING SITES -

- Schools (middle and high schools)
- School-Based Health Centers
- Residential Treatment Facilities
- Foster Care
- Drop-In Centers
- Shelters
- Clinics
- Juvenile Justice Facilities
- Pediatrician's Offices

COLUMBIA TEENSCREEN® PROGRAM

- SCREENING MODELS -

- **Single Screener Model (Tulsa, OK)**
- **SBHC Model (Juneau, AK)**
- **Agency Model (Yamhill County, OR)**
- **Shelter Model (Covenant House, FL)**
- **Alternative School Model (Tempe, AZ)**
- **Community Model (Clackamas County, OR)**
- **School Psychologist Model (Fond du Lac, WI)**
- **Boarding School Model (Culver Academies)**
- **SAP Model (Erie, PA)**
- **School Social Worker Model (Springfield, MA)**

COLUMBIA TEENSCREEN® PROGRAM

- HOW WE WORK -

- **Develop partnerships with communities across the nation to implement early-identification programs for suicide and mental illness in youth**
- **Screening programs based on the Columbia TeenScreen® Program will be adapted to the specific needs and resources of each community**

COLUMBIA TEENSCREEN® PROGRAM

— WHAT WE OFFER —

400 communities will receive free:

- Pre-training consultation
- Individually tailored screening projects
- Training
- Screening instruments
- Post-training technical assistance
- Screening materials

COLUMBIA TEENSCREEN® PROGRAM

- WHAT WE REQUIRE -

- Site Coordinator
- Completion of Site Application
- Letter of Agreement
- Minimum of 200 youth screened per year
- Commitment to screening routinization
- Biannual reporting of screening results
- We do not require data collection for research purposes

INSTRUMENT USE

Columbia TeenScreen® + Voice DISC

- Identification of suicide risk factors and psychiatric diagnosis

DPS

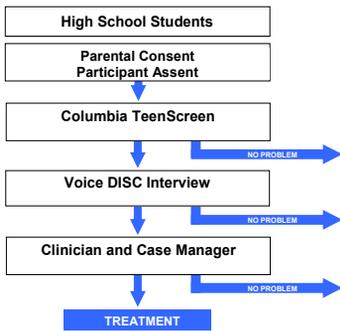
- Screen for broad range of psychiatric disorders

Voice DISC

- Diagnostic assessment of already identified students

COLUMBIA TEENSCREEN® PROGRAM

- Suicide Risk Model -



COLUMBIA TEENSCREEN® CHARACTERISTICS

- 10-minute, self-completion, paper-and-pencil survey
- Layperson administration & scoring
- Non-diagnostic
- Assesses for depression, substance abuse, suicide ideation and past attempts
- Highlights those who might be at risk
- Screens out those who are not at risk

VOICE DISC CHARACTERISTICS

(Diagnostic Interview Schedule for Children)

- Computerized diagnostic psychiatric interview
- Developed in 1979
- 9-17 year-olds
- 30+ Axis I DSM-IV disorders
- Layperson administration & scoring
- Present-state time frame
- 60-90 minute duration
- Automatic report of diagnoses, symptoms, impairment, and non-diagnostic salient symptoms

VOICE DISC TABLE OF CONTENTS

- **ANXIETY**
 - Social Phobia
 - Separation Anxiety
 - Specific Phobia
 - Panic*
 - Agoraphobia
 - Generalized Anxiety
 - Selective Mutism
 - Obsessive Compulsive
 - Post Traumatic Stress
- **MISCELLANEOUS**
 - Eating (Anorexia/Bulimia)
 - Elimination Disorders
 - Tic Disorders
- **MOOD**
 - Major Depression/Dysthymia*
 - Mania/Hypomania*
- **DISRUPTIVE BEHAVIORS**
 - Attention Deficit/Hyperactivity
 - Oppositional Defiant
 - Conduct
- **SUBSTANCE**
 - Alcohol Abuse, Dependence*
 - Nicotine Dependence
 - Marijuana Abuse, Dependence*
 - Other Substance Abuse, Dependence*

CLINICAL EVALUATION

- **Review TeenScreen**
- **Review DISC reports**
- **Triage**
- **Diagnostic impression**
- **Clinical summary**

ROLE OF CASE MANAGER

- **Informs parents of screening results and makes appointments**
- **Awareness of available resources**
- **Provides screening results to treatment provider**
- **Assists families until connection is made**
- **Promotes attendance at first appointment**

THE COLUMBIA TEENSCREEN PROGRAM

1998–1999 Results From Five NYC High Schools

Parental Consent

Letters Distributed	3021	
Consent Granted	1069	(35%)
Consent Refused	422	(14%)
No Response	1530	(51%)

TeenScreen Results

Total Screened	1015	
Positive Screen	653	(64%)
Thoughts of suicide	222	(22%)
Past suicide attempt	84	(8%)
Negative Screen	353	(35%)
Refused Participation	9	(1%)

Disposition of Students with Positive Screens

DISC Interviews	652	(64%)
DISC Positive	303	(46%)
Clinical Interviews	547	(54%)
Referred for Further Evaluation or Treatment	254	(25%)
Already in Treatment	24	(9%)

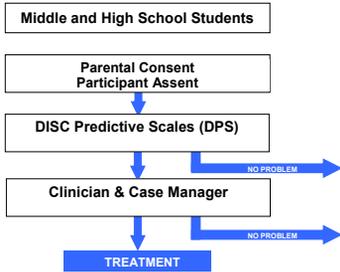
REFERRAL FOR TREATMENT IN A SCREENED POPULATION

Total screened	500
Needs evaluation/treatment	125 (25%)
Parent Refusals	24 (19%)
Fail first appointment	31 (25%)
One appointment only	21 (17%)
More than one appointment	48 (38%)

SCHOOL-BASED TREATMENT VS. OUTSIDE REFERRALS

	School	Outside
5-9 sessions	37%	45%
10+ sessions	54%	0%
5-10+	91%	45%

COLUMBIA TEENSCREEN® PROGRAM
- Mental Health Check-Up Model -



DPS CHARACTERISTICS

(DISC Predictive Scales)

- Self-completion mental health *screen*
- 9-17 year-olds
- Covers: social phobia, generalized anxiety disorder, panic disorder, OCD, major depression, alcohol abuse, marijuana abuse and other substance abuse
- Layperson administration & scoring
- 5-10 minute duration
- Computerized and paper and pencil versions
- English and Spanish versions
- Automatic report with symptoms and impairment
- 33% positive rate

COLUMBIA TEENSCREEN® PROGRAM

— RESULTS AND ADVANTAGES —

- 31% with MDD, 26% with suicide ideation and 50% of past attempters were already receiving help
- Identifies 73% who will be seriously depressed over the next 6 years
- Identifies 64% who will make a suicide attempt in the 6 years after screening

CONCLUSION

Screening in Mid-adolescence Identifies

- Students at risk for suicide
- Students who are now in distress from depression and other psychiatric disorders
- A high proportion of teens who will have a persistent depression and who will make a suicide attempt in their early twenties

COLUMBIA TEENSCREEN® PROGRAM

— HOW TO LEARN MORE —

Contact the TeenScreen office at

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Maternal and Child Health Bureau

Question and Answer Session
